



C. L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

# IDAHO DEPARTMENT OF HEALTH & WELFARE

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June 26, 2009

Renee Naylor  
Preferred Community Homes - Sunset  
7091 West Emerald Street  
Boise, ID 83704

Provider #13G052

Dear Ms. Naylor:

On **June 24, 2009**, a complaint survey was conducted at Preferred Community Homes - Sunset. The complaint allegations, findings, and conclusions are as follows:

## **Complaint #ID00004185**

**Allegation:** Staff abused an individual during a recent behavioral episode.

**Findings:** An onsite investigation was conducted from 6/23/09 - 6/24/09. During that time observations and interviews with staff and individuals were conducted, and investigations, incident and accident reports, behavioral data, training documentation and criminal history checks were reviewed with the following results:

Observation and interviews were conducted at the facility on 6/23/09 from 4:10 - 6:10 p.m. During that time, staff were observed to provide appropriate behavioral intervention. No incidents of abuse were identified during the observation.

Nine direct care staff were interviewed during the course of the survey. All 9 staff stated they had participated in multiple training sessions regarding abuse, neglect, and mistreatment including identifying, documenting, and reporting. All 9 staff stated they were not aware of any incidents of abuse, neglect, or mistreatment occurring with the current staff of the facility.

The facility's investigations, accident and injury reports, and behavioral data from 6/15/09 - 6/23/09 were reviewed. An incident on 6/21/09 documented an individual residing in the facility had eloped from the facility. Staff followed the individual towards a local park where the individual attempted to run into a street. The staff blocked the individual from running into the street, and redirected him towards the sidewalk. After 15 - 20 minutes the individual calmed and returned to the facility.

Four of the 5 staff involved with the incident were interviewed. All 4 staff stated the individual was blocked from attempting to enter the street. All 4 staff denied any aspect of the incident appeared to be abusive to the individual.

A random sampling of staffs' criminal background checks was reviewed. Of the four staff reviewed, all staff had completed fingerprinting prior to working with individuals, and all had received their clearance letters within the first two weeks of employment. All staff records reviewed documented drug screenings completed prior to working with individuals.

The facility's training documentation showed the facility had reviewed the abuse, neglect, and mistreatment policy's and procedures with all staff currently working at the facility.

Two individuals residing at the facility were interviewed, including the individual involved in the behavioral incident on 6/21/09. Both individuals stated they were happy at the facility and denied abuse, neglect, or mistreatment.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



MICHAEL A. CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/mlw